EXHIBIT D

Covington County Sheriff Printed: Tue May 03,2005	MEDICAL SCREENING FORM AL EVERITT BOYETT (S416081511)	Booking Number 200007743 Booking Date MAY 3rd, 2005

ADMISSION OBSERVATIONS

Is inmate conscious? (Y) N	Is inmate capable of responding? (Y) N	Can inmate walk on own? (Y) N
Any difficulty breathing? Y (N)	Is inmate hostile/aggressive? Y (N)	Any visible signs of trauma, bleeding, wounds or illness? Y (N)
Did arrest result in injury? Y (N)	Any fever, swollen lymph nodes, or jaundice? Y (N)	Is skin in good condition and free of vermin? (Y) N
Is inmate under obvious influence of alcohol? (Y) N	Is inmate under obvious influence of drugs? Y N	Any visible signs of alcohol or drug withdrawal symptons? Y (N)
Does inmate suggest risk of suicide? Y (N)	Do you consider inmate an escape risk? Y (N)	

Observations
WOULD NOT ANSWER QUESTION ON INFLUENCE OF DRUGS

INMATE QUESTIONNAIRE

HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?

Hepatitis (Y) N	Heart Disease Y (N)	Mental/Emotional Upset (Y) N
Tuberculosis Y (N)	Hypertension Y (N)	Attempted Suicide Y (N)
Sexually Transmitted Disease Y (N)	Epilepsy/Convulsions Y (N)	Asthma/Emphysema Y (N)
Ulcers Y (N)	Hemophiliac (bleeder) (Y) N	Cancer Y (N)
Kidney Trouble Y (N)	Aids/Exposed to Aids Y (N)	Diabetes Y (N)
DT's Y (N)	Skin Problems Y (N)	Use Insulin Y (N)
Drug Addiction Y (N)	Alcholism Y (N)	Mental Illness Y (N)
Recent Head Injury Y (N)	Coughed/Passed Blood Y (N)	Recent Hospital Patient Y (N)
Recent Treatment Y (N)	Use Needles (Y) N	False Limbs/Teeth Y (N)
Contagious Disease Y (N)	Pregnant/Recent Delivery Y (N)	

Doctors Name and Address
NO

Health Insurance
NO

Special Diet

I have read the above carefully and have answered all questions

Inmate's Signature X

Officers's Signature

MEDICAL STAFF RE[illegible]ING SCREENING FORM

Southern Health Partners

LAST NAME: [illegible] FIRST NAME: [illegible] MIDDLE: [illegible] INTAKE DATE: [illegible] SCREENING DATE: [illegible] TIME: [illegible]

PREVIOUS INCARCERATIONS: SEX: SOCIAL SECURITY NO: DOB:

CURRENT INSURANCE COVERAGES? CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION:

VISUAL / MEDICAL OBSERVATION: *(Explain all "Yes" Answers) Circle Y or N:*	YES
Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral? If yes:	Y
Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries; needle marks, body vermin? If yes:	Y
Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior? If yes:	Y
Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol? If yes:	Y
Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc. If yes:	Y

ASK THE INMATE THESE QUESTIONS: *(Explain all "Yes" answers)*	
Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions? Other:	Y
Have you taken or are you taking any medication(s) prescribed for you by a physician? If yes:	Y
Are you allergic to any medications, foods, plants, etc.? If yes:	Y
Have you fainted or had a head injury within the last 72 hours? If yes:	Y
Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease? If yes: [illegible]	Y
Have you been hospitalized by a physician or psychiatrist within the last year? If yes:	Y
Have you ever considered or attempted suicide? If yes:	Y
Do you have a painful dental condition? If yes: [illegible]	Y
Are you on a specific diet prescribed by a physician? If yes:	Y
Do you use drugs? How often? [illegible] Last time? What kind? How much?	Y
Do you use alcohol? How often? [illegible] Last time? What kind? [illegible] How much?	Y
Females: LMP Date: Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge? If yes:	Y

NOTE VITAL SIGNS:

Respiration: [illegible]	Pulse: [illegible]	Temperature: [illegible]	Blood Pressure: [illegible]

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? [illegible]

ARE ALL STATED CHRONIC CONDITIONS NOTED: [illegible]

PPD IMPLANTED? Y OR N ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS: [illegible]

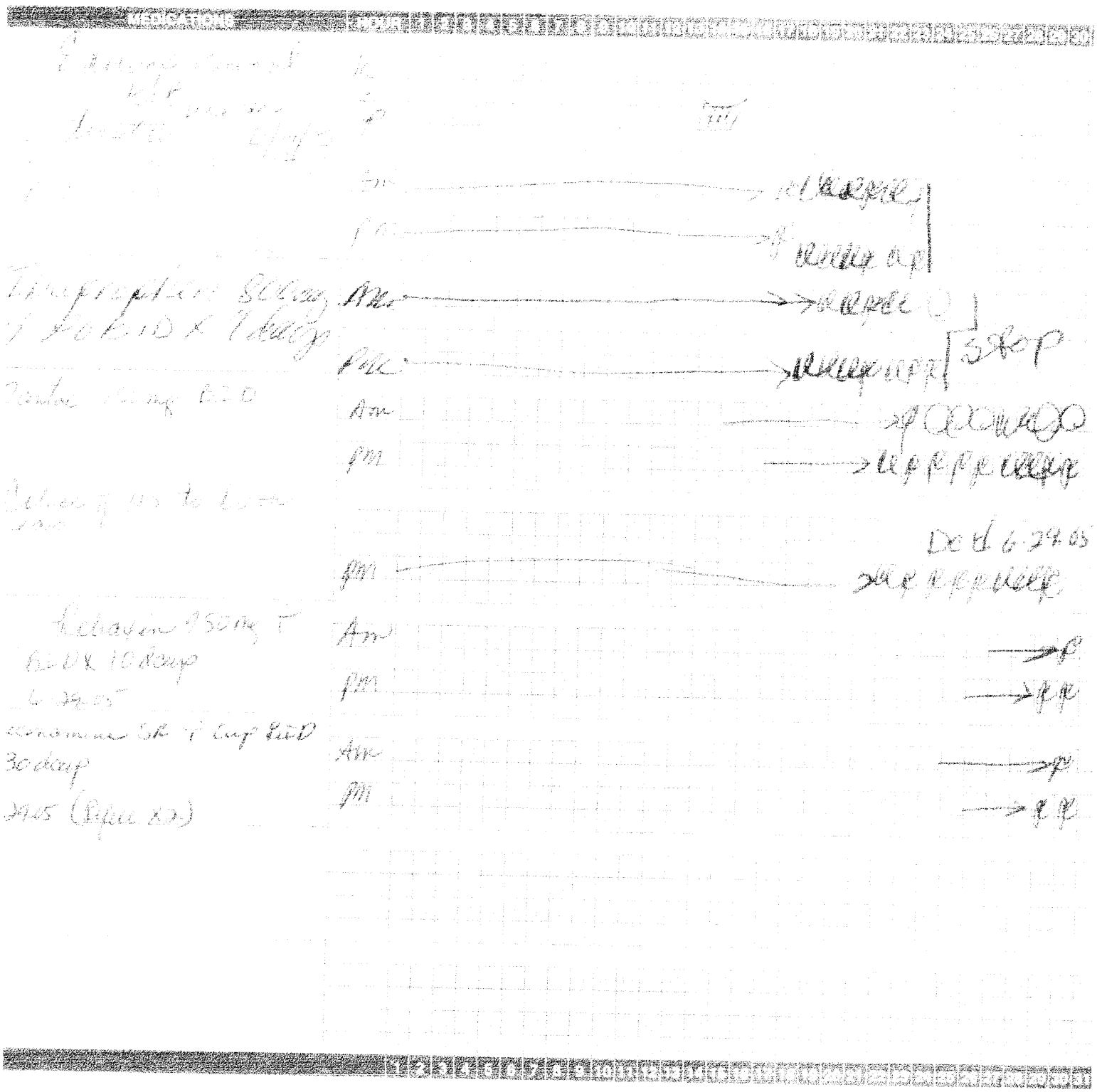
REMARKS:

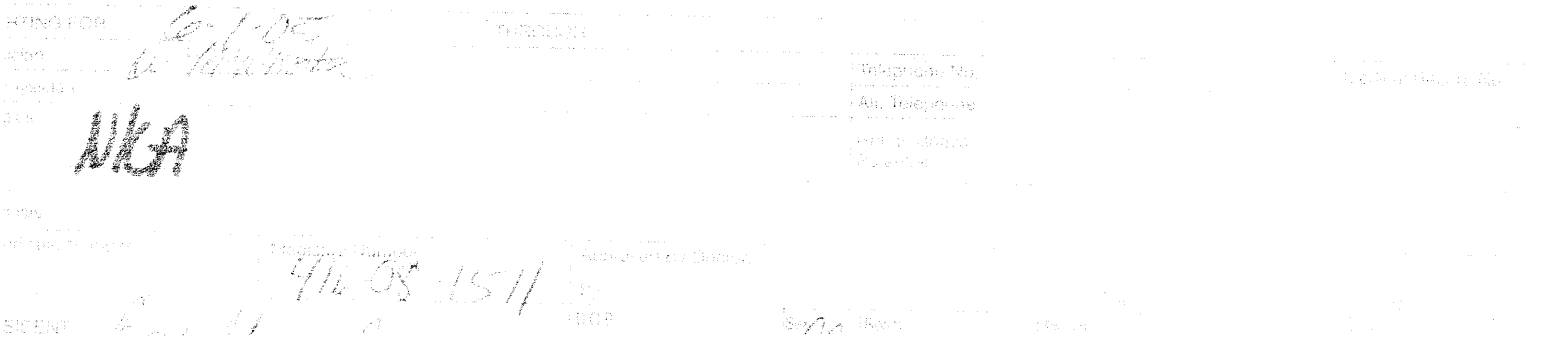
I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication up hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Inmate's Signature: [illegible] Date: [illegible]

Interviewer's Signature and Title: [illegible] Date: [illegible]

MEDICATION ADMINISTRATION RECORD





Covington County Sheriff Printed: Wed Jun 08,2005	**MEDICAL SCREENING FORM** **AL EVERITT BOYETT (S416081511)**	Booking Number 200008027 Booking Date JUNE 7th, 2005

ADMISSION OBSERVATIONS

Is inmate conscious? (Y) N	Is inmate capable of responding? (Y) N	Can inmate walk on own? (Y) N
Any difficulty breathing? Y (N)	Is inmate hostile/aggressive? Y (N)	Any visible signs of trauma, bleeding, wounds or illness? Y (N)
Did arrest result in injury? Y (N)	Any fever, swollen lymph nodes, or jaundice? Y (N)	Is skin in good condition and free of vermin? (Y) N
Is inmate under obvious influence of alcohol? Y (N)	Is inmate under obvious influence of drugs? Y (N)	Any visible signs of alcohol or drug withdrawal symptons? Y (N)
Does inmate suggest risk of suicide? Y (N)	Do you consider inmate an escape risk? Y (N)	

Observations

INMATE APPEARS FINE AT TIME OF INTAKE

INMATE QUESTIONNAIRE

HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?

Hepatitis (Y) N	Heart Disease Y (N)	Mental/Emotional Upset Y (N)
Tuberculosis Y (N)	Hypertension Y (N)	Attempted Suicide Y (N)
Sexually Transmitted Disease Y (N)	Epilepsy/Convulsions Y (N)	Asthma/Emphysema Y (N)
Ulcers Y (N)	Hemophiliac (bleeder) Y (N)	Cancer Y (N)
Kidney Trouble Y (N)	Aids/Exposed to Aids Y (N)	Diabetes Y (N)
DT's Y (N)	Skin Problems Y (N)	Use Insulin Y (N)
Drug Addiction Y (N)	Alcholism Y (N)	Mental Illness Y (N)
Recent Head Injury Y (N)	Coughed/Passed Blood Y (N)	Recent Hospital Patient Y (N)
Recent Treatment Y (N)	Use Needles Y (N)	False Limbs/Teeth Y (N)
Contagious Disease Y (N)	Pregnant/Recent Delivery Y (N)	

Doctors Name and Address

NONE

Health Insurance

NONE

Special Diet

NONE

Prescriptions/Medications

NONE

Drug Allergies

NONE AWARE OF

Descriptions

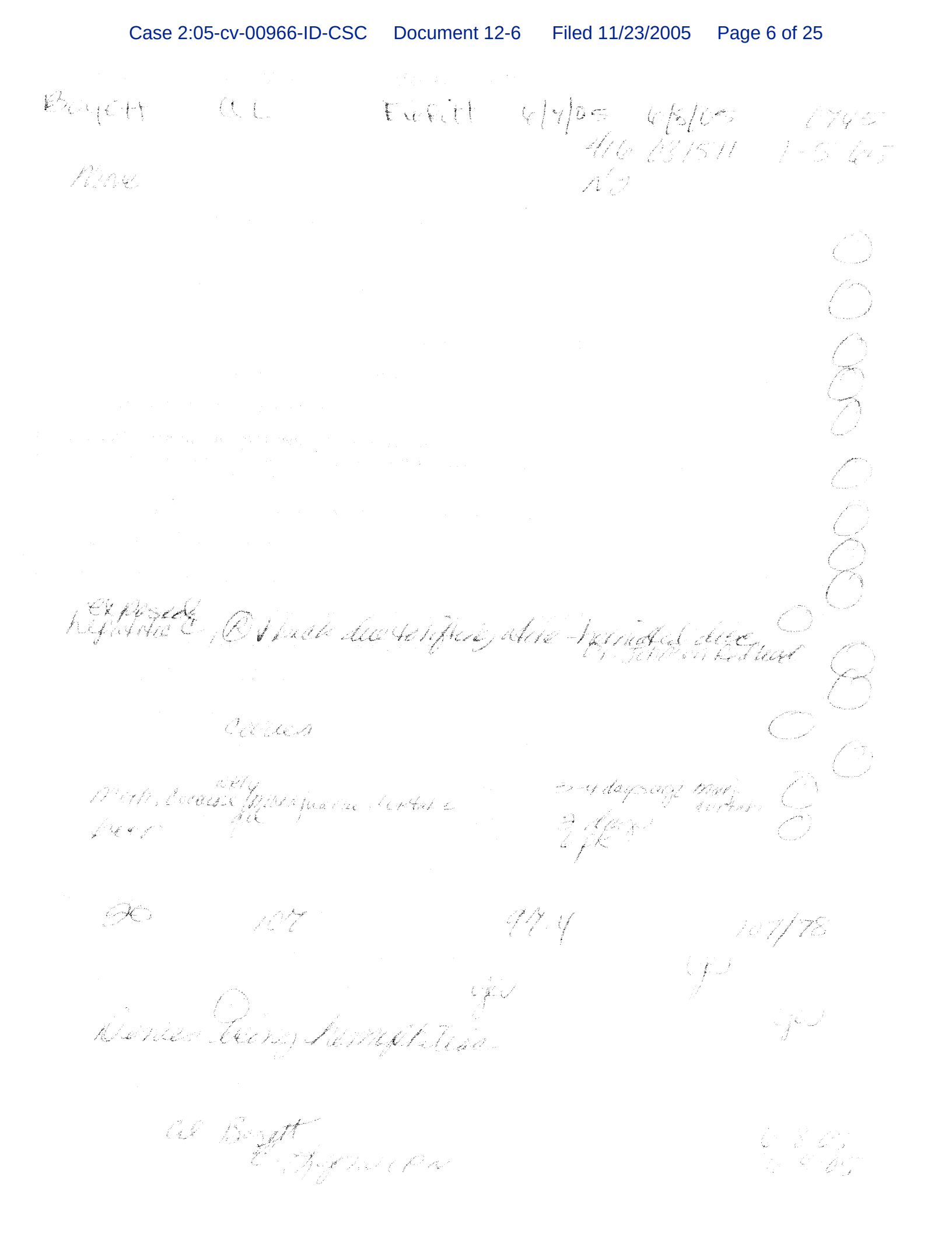
INMATE APPEARS FINE AT TIME OF INTAKE

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature _____ Date: _____ Time: _____

Officers's Signature _____ Date: _____ Time: _____

CJ012 PORTREY, CLIFF



SOUTHERN HEALTH PARTNERS

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the corre officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for yo seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay sys this facility.

Today's Date: 6-13-05 Pod/Location: [illegible] Cell: [illegible] ID#

Inmate's Full Name: [illegible]

Complaint/Problem: [illegible]

How long have you had this problem? 6-12-05

Inmate's Signature: [illegible] Date: [illegible]

********** ********** ********** ********** ********** ********** ********

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp [illegible] Resp [illegible] Pulse [illegible] B/P [illegible]

Instructions/Assessment: Document your findings, Inmate's responses/actions

[illegible]

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: [illegible] Seen by: [illegible]

Place original form in patient's medical record.

[illegible]

SOUTHERN HEALTH PARTNERS

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the cor officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for y seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay s this facility.

Today's Date: [illegible] Pod/Location: [illegible] Cell: [illegible] ID#: ______

Inmate's Full Name: Al Boyett

Complaint/Problem: My ear popped and is ringing and I need to see the doctor immediately

How long have you had this problem? Since Tuesday of this week [illegible] started

Inmate's Signature: Al Boyett Date: 6-17-05

********** ********** ********** ********** ********** ********** *******

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 96.8 Resp 20 Pulse 78 B/P 106/64

Instructions/Assessment: Document your findings, Inmate's responses/actions

Refer to M.D.
Both ears impacted c wax (earwax removed [illegible])
Ibuprofen 800mg i po BID x 7 days
Leg cramps (No charge for this visit)
[illegible]

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
☐ Follow-Up Required? If checked, date to be seen again ______
☐ Chronic Condition
☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6/18/05 Seen by: [illegible]

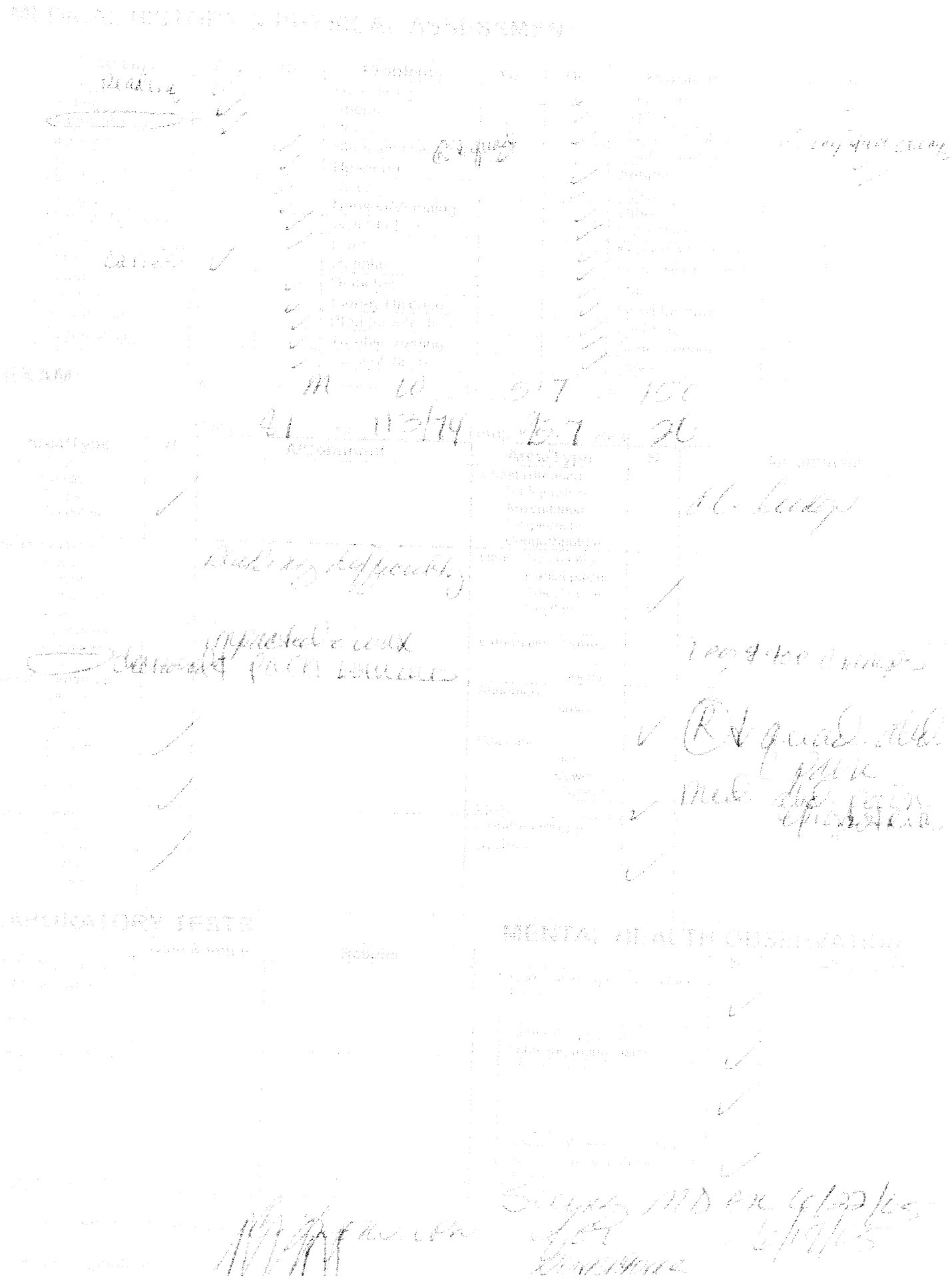
Place original form in patient's medical record.

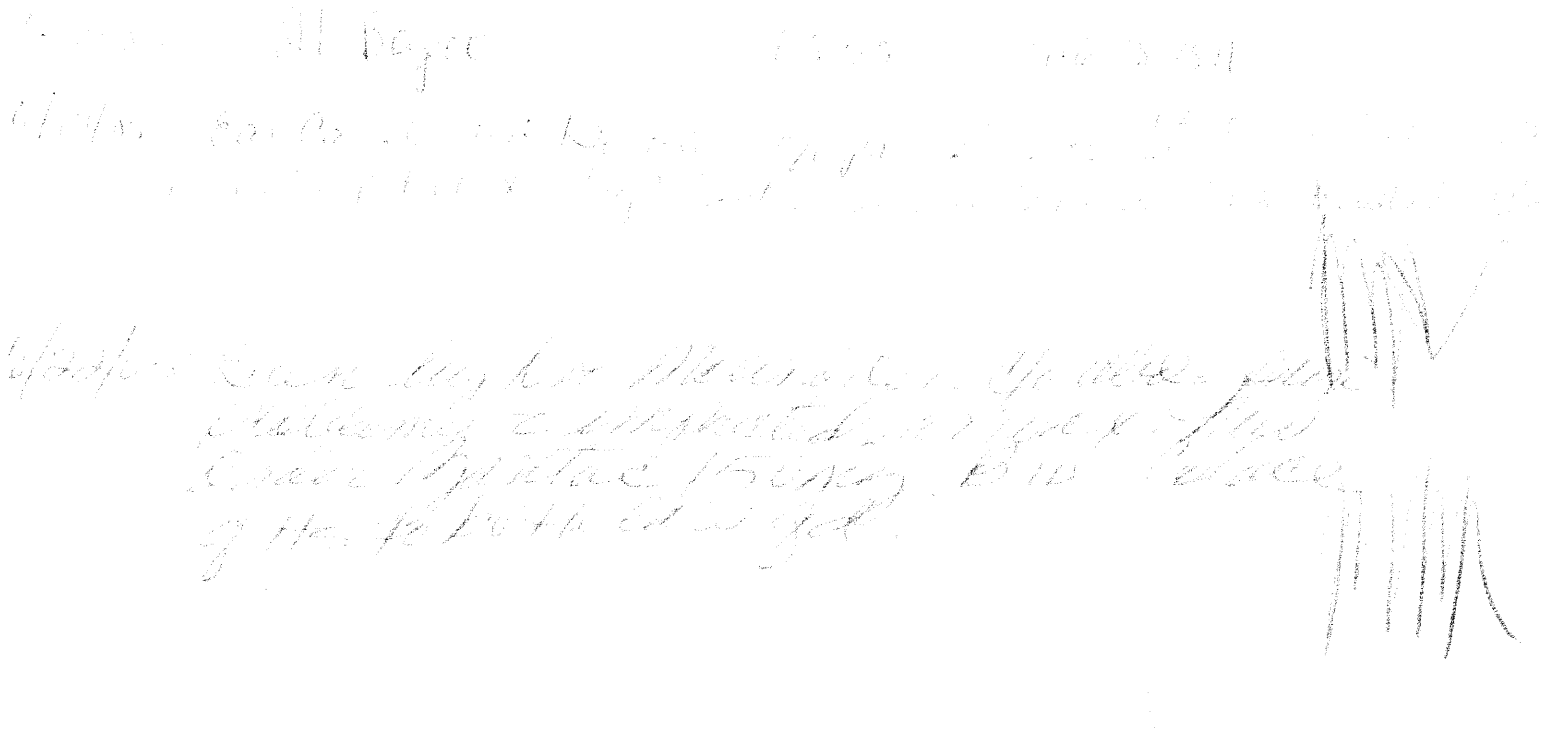
MENTAL HEALTH EVALUATION

NO

NO

NO





SOUTHERN HEALTH PARTNERS

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the co officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay s this facility.

Today's Date:_____ Pod/Location:_____ Cell:_____ ID#_____

Inmate's Full Name:_____

Complaint/Problem:_____

How long have you had this problem?_____

Inmate's Signature:_____ Date:_____

********** ********** ********** ********** ********** ********** ********

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp_____ Resp_____ Pulse_____ B/P_____

Instructions/Assessment: Document your findings, Inmate's responses/actions_____

Referred to MD

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
☐ Follow-Up Required? If checked, date to be seen again_____
☐ Chronic Condition
☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical:_____ Seen by:_____

Place original form in patient's medical record.

COVINGTON COUNTY JAIL
INAMTE REQUEST/GRIEVANCE FORM

NAME: _____ BLOCK: _____ DATE: _____

TELEPHONE CALL CUSTODY CHANGE ( ) PERSONAL PROBLEM

SPECIAL VISIT TIME SHEET ( ) OTHER ( ) GRIEVANCE

PLEASE OUTLINE YOUR REQUEST/ GRIEVANCE. THEN PRESENT TO C/O

REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO

SHERIFF CHIEF JAILER ( )JAILER ( )RECORDS OFFICE (CHAPLIAN

GRIEVANCE STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF APPLICABLE

DO NOT WRITE BELOW THIS LINE - FOR REPLY ONLY:

APPROVED ( ) DENIED ( ) PAY PHONE ( ) COLLECT ( ) OTHER

SOUTHERN RADIOLOGY SERVICES, LLC
X-RAY REPORT

DATE	LAST NAME	FIRST NAME	MI
8/16/2005	[redacted]	AL	
DOB	SEX	FACILITY	
6/15/1965	M	SUPERVISING [redacted]	
ORDERING PHYSICIAN		X-RAY NO.	
NON-VETER			

IMAGES OF THE LEFT HAND, 8/16/05

HISTORY: Patient

Patient had trauma the week prior. Patient sustained a fracture to the neck of the fifth metacarpal without gross displacement. There is no dislocation noted either. No additional acute fracture is identified. There is a prominent spur at the distal end of the fifth digit proximal phalanx that could be related to the old trauma. No acute foreign bodies suggested.

IMPRESSION: Nondisplaced fracture of the distal fifth metacarpal.

[redacted], MD/Date

D: 8/16/2005 12:48:12 PM
T: 8/16/2005 12:37:50 PM

PROGRESS NOTES

Notes Should Be Signed by Physician

Southern Health Partners, Inc.

ADMISSION DATA / HISTORY AND PHYSICAL FORM

Intake Date: _____ S.S.#: _____ ID#: _____

Inmate Name: _____ (Last) _____ (First) _____ (Middle) Date Booked: _____

Alias: _____ (Last) _____ (First) _____ (Middle) County: _____

Address: _____ (Street) _____ (City) _____ (State) _____

Telephone: _____ Birthdate: _____ Religion: _____

Education Completed: _____ Special Education: _____

Marital Status: (S) M W D Separated Read/Write English: (YES) NO Other: _____

Previous Incarceration: (Facility/Date) _____

MEDICAL HISTORY

Notify in Emergency: _____ (Name) _____ (Relationship)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Phone: _____

Health Insurance: _____ (Type of Insurance)

Family Physician: _____ (Name) _____ (Street Address) _____ (City) _____ (State) _____ (Zip) _____ (Policy Number) _____ (Phone Number)

Past Hospitalizations (include surgeries): _____

_____ (Location) _____ (Street Address) _____ (City) _____ (State) _____ (Zip)

Head Injury with Loss of Consciousness: _____ Last Tetanus: _____ (Day) _____ (Month) _____ (Year) Immunization: _____

Allergies: _____

Current Medication(s): _____

MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: (YES) NO If Yes, Why: _____

Where: _____ (Location) _____ (Street Address) _____ (City) _____ (State) _____ (Zip) When: _____ (Date)

Psychotropic Meds (Specify type and last dose): _____

Prior Counseling/Out-Patient Treatment for: _____

Where: _____ (Location) _____ (Street Address) _____ (City) _____ (State) _____ (Zip) When: _____

Have you ever attempted suicide: _____ How: _____ When: _____ (Date)

Have you recently considered committing suicide? _____

Do people consider you a violent person? _____

Have you ever been arrested for a violent crime/sexual offense? (Specify) _____ (Year)

Street drugs: _____ (How Often) _____ (How Long) Smoker: _____ Etoh: _____

Inmate's Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____

Witness to physical is refused: _____ Date: _____

MEDICAL HISTORY & PHYSICAL ASSESSMENT

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Vision			Hypertension			Gonorrhea		
Hearing			Anemia			Syphilis		
Dizziness/Faintness			Blood			Muscle Problem		
Blackouts			Stomach Pain			Joint Problem		
DTs			Heartburn			Arthritis		
Headaches			Ulcer			Other		
Seizures			Nausea/Vomiting			Other		
Nervous Disorder			Gall Bladder			Regular Menstrual Period		
Throat			Liver			Irregular Menstrual Period		
Teeth			Hepatitis			# of days between periods		
Asthma			Diabetes			LMP		
Hay Fever			Kidney Disease			Gravida/Para		
Pneumonia			Bladder Infection			Last Pap		
Tuberculosis			Trouble Voiding			Contraception		
Heart			Pediculi (lice)			Other		

EXAM: Age 42 Sex M Race W Ht 5'12" Wt 165

Pulse BP (sitting) Resp.

Area/Type	N	A/Comment	Area/Type	N	A/Comment
Skin: Color, Condition, Turgor, Recent Inj		Tattoo, [illegible], [illegible] Scars	Chest (Breasts): Configuration, Auscultation, Respirations, Cough/Sputum	✓	
Head: Glasses, Pupils, Sclera, Conjunctiva, Vision	✓		Heart: Auscultation, Radial pulses, Apical pulse, Rhythm	✓	
Ears: Appearance, Canals, Hearing	✓		Extremities: Pulses, Edema, Joints	✓	
Mouth: Teeth/Gums, Dentures, Palate, Throat, Tongue, Tonsils			Abdomen: Shape	✓	
Nose	✓		Palpation: Hernia, Bowel Sounds	✓	
Neck: Veins, Midline, Thyroid, Carotids, Lymph	✓		Spine	✓	
Notes			Genital/Urinary System	✓	

LABORATORY TESTS

	Date & Initial	Results
Was PPD planted and read timely?	[illegible]	[illegible]
VDRL / RPR	[illegible]	
Other Lab Tests ordered	[illegible]	
Pregnancy Test?		

MENTAL HEALTH OBSERVATION

	N	A/Comment
Orientation (person, place, time)	✓	
General appearance (grooming, behavior, mannerisms)	✓	
Affect (mood)		
Content of thought, hallucinations, suicide, present thoughts of suicide		None

Physician Examiner's Signature: [illegible] Date: [illegible]

Physician's Signature: [illegible]

HEALTH PARTNERS

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TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the corre officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay syst this facility.

Today's Date: Pod/Location: Cell: ID#

Inmate's Full Name:

Complaint/Problem:

How long have you had this problem?

Inmate's Signature: Date:

********** ********** ********** ********** ********** ********** ********** **********

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp Resp Pulse B/P

Instructions/Assessment: Document your findings, Inmate's responses/actions

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
☐ Follow-Up Required? If checked, date to be seen again
☐ Chronic Condition
☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: Seen by:

Place original form in patient's medical record.

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of [illegible] and review by the medical staff. [illegible] You will be charged [illegible]

Today's Date [illegible] Pod/Location [illegible]

Inmate's Full Name [illegible]

Complaint/Problem [illegible]

How long have you had this problem? [illegible]

Inmate's Signature [illegible] Date 10-?-05

TO BE COMPLETED BY MEDICAL STAFF:

Vital Signs: Temp _____ Resp [illegible] Pulse [illegible] BP [illegible]

Subjective / Assessment: Document any findings, inmate's responses/actions

[illegible]

[illegible] Treatment Protocol via telephone order [illegible]

[illegible] date to be seen again [illegible]

[illegible] medical co-pay for this visit

[illegible]

Doctor SICK CALL REFUSAL FORM

I, H. Bryett (inmate name) understand that my name is on the sick call list to be seen by Southern Health Partners medical staff at Covington County Jail, and that I am declining to be seen at this time. I further understand that it will be documented as such in my medical file, and that my name will NOT be added back to sick call, unless I submit another sick call request.

H. Bryett
Inmate Signature

Date/Time

Witness Signature

Date/Time

Nurse Signature

Date/Time Noted

Southern Health Partners

Revised 02/05/03

Distribution: Original-Nurse

COVINGTON COUNTY JAIL
INMATE REQUEST/GRIEVANCE FORM

NAME ____________________ BLOCK ________ DATE ____________

TELEPHONE CALL   CUSTODY CHANGE   PERSONAL PROPERTY

SPECIAL DIET   TIME SHEET   (✓) OTHER   ( ) GRIEVANCE

BRIEFLY OUTLINE YOUR REQUEST/ GRIEVANCE, THEN PRESENT TO C/O

IF REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO
SHERIFF   CHIEF JAILER   ( )JAILER   ( )RECORDS OFFICE   CHAPLAIN

IF GRIEVANCE STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF APPLICABLE.

[illegible]

Would [illegible] appointment [illegible]

[illegible]

[illegible] reply.

[illegible] Inmate requesting Hep. C profile to [illegible] length of Rx

BELOW THIS LINE IS FOR REPLY ONLY:

APPROVED   DENIED   ( ) PAY PHONE   COLLECT   ( ) OTHER

INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE [illegible]

[illegible]

Date [illegible] Location [illegible]

Inmate's Full Name [illegible]

Complaint/Problem [illegible]

[illegible]

How long have you had this problem? [illegible] week

Inmate's Signature [illegible]

TO BE COMPLETED BY MEDICAL STAFF:

Patient's Vital Signs: Temp ______ Resp ______

Evaluation/Assessment: Document your findings. Inmate [illegible] See Above

[illegible] inmate has [illegible] on his leg and [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Date [illegible]

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Zantac 150 mg PO BID	am																														
	pm																														
[illegible] BID x 10 days	am						/																								
	pm						/																								
[illegible] SR 1 cap BID x 30 days (Refuse x2)	am																													/	
	pm																													/	
[illegible] BID [illegible]	am																														
	pm																														

CHARTING FOR 7-1-05 THROUGH 7-31-05

Resident [illegible]

Physician

Allergies NKA

Telephone No.

Alt. Telephone

Rehabilitation Potential

Medicaid Number 416-08-1511